DSS-191
R. 3/90

Commonwealth of Kentucky
Cabinet for Families and Children
Department for Community Based Services

INFORMATION TO BE OBTAINED FROM PLACING PARENT

This form is designed to gather health history, genetic and social background information from birth parents which will be helpful to adoptive parents in parenting the child. It is important that they have this information so that it can become a part of their family history. Perhaps it will be most important when the child begins to ask questions. Answers will then be readily available about interests, talents, appearance, medical and genetic history. For these reasons, please be as thorough as possible in answering all of the questions. (Names and identifying information will not be shared with adoptive parents.)

The following information is true and complete to the best of my knowledge and belief.

Signed: _____

Date Form Completed _____ By Whom _____

Name: _____ Social Security # _____

Current Address: _____
Street City State Zip

How Long at This Address: _____

Permanent Address: _____
(If Different) Street City State Zip

Birthdate _____ Birthplace _____

MARITAL HISTORY

Are you currently married? Yes___ No___ If yes, give name and address of current spouse and date of marriage.

_____

Have you been married previously? Yes____ No____ If yes, list dates and places of marriages and divorces from, or deaths of spouses. _____

Is the child being placed, the child of your current spouse? Yes_____ No_____ If not, give the name of the other parent. _____

CHILDREN OTHER THAN CHILD TO BE ADOPTED (If you have other children, list them below. Include any children previously placed for adoption. If any child is deceased, please provide cause of death).

NAME	BIRTHDATE	BIRTHPLACE	SIBLING Full	SIBLING Half	CURRENT ADDRESS / WITH WHOM

If any children listed above had unusual physical or mental illness, give details. _____

_____

_____

Form Completed on

BIRTH MOTHER ____

BIRTH FATHER ____

PHYSICAL CHARACTERISTICS

Eyes:_____Hair:_____Complexion:_____Height:_____Weight:_____Body Build:_____

Race:_____Nationality/Descent:_____Blood Type:_____Rh Factor:_____

Do you wear glasses? Yes___No___ Right/Left Handed:_____

EMPLOYMENT INFORMATION

Are you employed? Yes___No____Current Employment (type of job):_____

Previous Employment (type of job):_____

EDUCATION

Number of years attended: Grade School_____High School_____College_____

Vocational and other training:_____

RELIGION

Do you have a preference regarding the religious practice of the adoptive family for your child? Yes___No___

If yes, please specify:_____

Would you object to your child being placed with a family whose religion is different from your own? Yes___No___

REASONS FOR PLACEMENT

Why did you consider it desirable to place the child for adoption?_____

_____

_____

If child not placed at birth, give brief information on health and development until the time placement was made.

_____

_____

_____

_____

_____

What is your current feeling about being contacted by the child when he/she is an adult?

_____

_____

_____

_____

_____

FAMILY HISTORY

Background: Please give a brief description of your childhood home and family life.

YOUR DEVLOPMENTAL HISTORY

EVENT	AT WHAT AGE	EVENT	AT WHAT AGE
Ist Tooth		Weaned	
Crawled		Food Problems	
Walked		Bed Wetting	
Toilet Trained		Onset of menses (mother)	
Talked		Any problems? Yes __No __	
		Acne?	

Please give a brief description of what your interests are now. Do you have any special talents or abilities? Do you have any specific goals toward which you would like to work?

Name of Child _____

BACKGROUND INFORMATION FOR PREGNANCY WITH THIS CHILD(To be completed by birth mother only)

Is the baby's father aware of the pregnancy? Yes _____ No _____ Not Sure _____
Is the baby's father a genetic relative of yours? Yes _____ No _____ If yes, how is he related?

Month prenatal care began for this pregnancy: _____
Were there any complications? Yes _____ No _____ If yes, explain _____

Was there any sexual or physical abuse during pregnancy? Yes _____ No _____
Was there any veneral disease and treatment during pregnancy? Yes _____ No _____
Food cravings during pregnancy: Yes _____ No _____

MEDICATION AND OTHER SUBSTANCES USED DURING THIS PREGNANCY AND DURING 5 YEARS PRIOR TO PREGNANCY

Indicate in appropriate space medication/drugs taken during pregnancy involving this child and or other substances used during the 5 years prior to this pregnancy.

MOTHER ONLY	Yes (check one)	No (check one)	Month (If during this pregnancy)	Year (If prior to this pregnancy)	Type, frequency and Amount
01. Aspirin					
02. Antibiotics					
03. Antihistamines					
Indicate type(s)_____					
04. Hormones					
Indicate type(s)_____					
05. Cortisone (ACTH, etc.)					
06. Diet pills					
Indicate type(s)_____					
07. Sleeping pills					
Indicate type(s)_____					
08. Nerve pills/tranquilizers					
Indicate type(s)_____					
09. Medicine for cancer					
Indicate type(s)_____					
10. Heart/blood pressure pills					
Indicate type(s)_____					
11. Thalidomides					
12. Medicine for nausea					
Indicate type(s)_____					
13. Medicine for convulsions					
Indicate type(s)_____					
14. Nose drops					
15. Alcohol					
16. Amphetamines					
Indicate type(s)_____					
17. Barbiturates					
Indicate type(s)_____					
18. Cocaine					
19. Heroin					
20. LSD					
21. Marijuana					
22. Caffein (coffee, tea,etc.)					
23. Use tobacco					
Indicate type(s)_____					
24. Any other prescription drugs, if yes indicate type(s) _____					

FATHER ONLY				
01. Alcohol				
02. Amphetamines				
03. Barbiturates				
04. Cocaine				
05. Heroin				
06. LSD				
07. Marijuana				
08. Caffein (coffee, tea,etc.)				
09. Use tobacco				
10. Any other prescription drugs, if yes				
11. Any known veneral disease and treatment				

FAMILY OF BIRTH PARENT

RELATIVES: (Give information shown below. Star the names of any who know the child, if you are willing for them to be contacted.) If relative is deceased, write cause of death in the address space.

NAME	ADDRESS	AGE	RACE	EDUCATION	OCCUPATION	PHYSICAL DESCRIPTION				
						HEIGHT	WEIGHT	HAIR	EYES	COMPLEXION
Mother of birth parent										
Other children of birth parent										
Father of birth parent										
Brothers of birth parent										
Sisters of birth parent										
Grandparents of birth parent										

MEDICAL BACKGROUND

Name of Child _____

Form completed on
BIRTH MOTHER ___
BIRTH FATHER ___

Please remember, we are trying to give as complete a medical history for the child as possible. Indicate if the birth parent, grandparents, siblings, or other extended family members (blood relatives) have had or now have the medical item listed below. Where appropriate, give age at onset, treatment, medication, etc. Use additional space if needed.

MEDICAL CONDITION	SELF Yes	SELF No	FAMILY Yes	FAMILY No	COMMENTS (indicate which family member)
Birth Defects, e.g., harelip, club foot, congenital heart defect, birth marks, Hydrocephalus					
Paralysis or crippling disorder, e.g., muscular dystrophy, multiple sclerosis, cerebral palsy, spina bifida					
Seizures, convulsions or epilepsy - age at onset					
Sight, hearing or speech impairment					
Learning disability					
Mental retardation, e.g., Down's Syndrome, etc.					
Hormonal disorder, e.g., Diabetes, thyroid - age at onset					
Arthritis					
Allergies, e.g., food, drugs, asthma or hay fever, eczema, etc.					
Blood diseases e.g., hemophilia (bleeding), sickle cell anemia, hepatitis, anemia					
Kidney disorder					
Cardiovascular problems, e.g., high blood pressure, stroke, heart attack					
Schizophrenia, severe depression, suicide					
Alcoholism/Drug abuse					
Cancer (type/location)					
Significant illness, e.g., Cystic Fibrosis. Lupus, etc.					
Spontaneous abortions, miscarriages, stillbirths, neonatal deaths, high/low birth weight, prematurity, Toxemia, twins					
Viral infections, Encephalitis, Herpes, AIDS, etc.					
Huntington's Disease, Tay-Sachs, Neurofibromatosis, PKU, Tuberculosis, Toxoplasmosis Disease					
Venereal Disease					
Special dental problems					

INFORMATION TO BE OBTAINED FROM PLACING PARENT
(For Independent Placement Only)

1. Why have you chosen to place the child independently rather than through an adoption agency?

2. Have you met (or talked with) the adopting parents? Yes___No____

   a. If yes, how long have you known them?_____

   How well acquainted are you with them?_____

   b. If no, how did you become aware of the prospective adoptive family? Who arranged the placement? Please be specific._____

3. Have the adopting parents or their representative paid (or agreed to pay) any of the expenses of the child's birth and care, or assisted (or agreed to assist) in any other way with financial payments or material goods? Yes____No _____ If yes, please give the specifics. _____

   If yes, has this in any way affected your decision regarding the placement planning for your child?

4. Are you satisfied with the information you have received concerning the adoptive parents?